2018 External Quality Review

SOUTH CAROLINA SOLUTIONS

Submitted: August 6, 2018

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The purpose of this review is to determine the level of performance demonstrated by South Carolina Solutions (Solutions). This report contains a description of the process and the results of the *2018 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

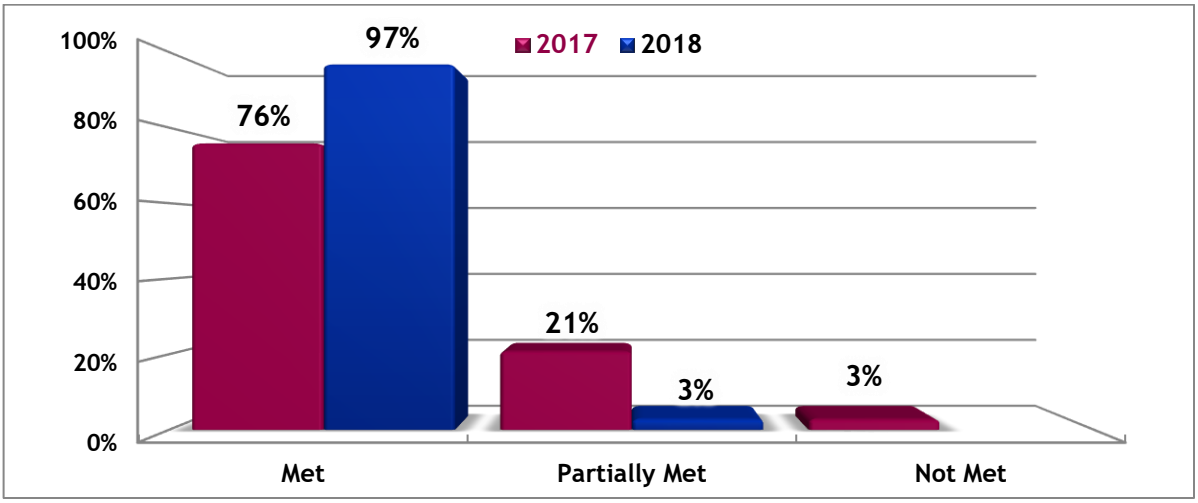
- Determine if Solutions was in compliance with service delivery as mandated in their contract with SCDHHS.
- Provide feedback for potential areas of further improvement.
- Assure that contracted health care services are actually being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review included a desk review of documents and onsite visit.

Overall Findings

The 2018 annual EQR shows that Solutions has achieved a “Met” score in 97% of the standards reviewed. As the following chart indicates, 3% of the standards were scored as “Partially Met.” The chart that follows also provides a comparison of Solutions’ current review results to the 2017 review results.

Figure 1: Annual EQR Results



An overview of the findings for each section follows. Details of the review, as well as specific strengths, weaknesses, any applicable quality improvement items, and recommendations can be found further in the narrative of this report.

Administration:

Community Health Solutions (CHS) of America Inc. is the parent company of South Carolina Solutions (Solutions). The CHS Board of Directors (BOD) and Executive Committee provide corporate-level governance for Solutions. Local operations meetings are attended by both local and corporate leadership and local staff.

Within the last year, Solutions nearly doubled its staff and created and filled a Lead Care Advocate position. Solutions plans to add a second Resource Nurse position. Currently 29 Care Coordinators and five Care Advocates provide services to Solutions' participant population of approximately 1,100. Personnel files reviewed confirm Solutions conducts appropriate due diligence to ensure staff meet all contractual requirements and have not been excluded from participation in state or federal programs.

The designated Compliance Officer oversees and manages all aspects of the Compliance Program and conducts investigations of alleged compliance and confidentiality issues. Issues are reported to the Quality Management Committee (QMC) and Executive Committee, as well as the BOD. Programs are in place to provide HIPAA and compliance training to staff, providers, and other individuals or entities with whom Solutions does business. Solutions' website provides phone numbers and email addresses to which suspected Fraud, Waste, and Abuse (FWA) can be reported to both CHS and the SCDHHS Medicaid Fraud and Abuse Hotline.

Solutions has established policies and procedures that address access to, and data security for, protected health information (PHI), including how the organization manages access to PHI and measures for staff to handle PHI in a confidential manner.

Solutions' detailed *Disaster Recovery Plan* is regularly reviewed and revised. It specifies teams associated with response and recovery efforts, steps associated with recovery phases, and contact information for responsible parties. Documentation included a recent recovery effort resulting in a successful system restoration.

Provider Services:

CCME reviewed documents and reference materials used by the Plan to educate contracted providers. The Provider Orientation/Training Policy defines a consistent process for onboarding new providers to the physician network. Face-to-face provider orientations are completed within 30 days of contracting with Solutions. The Provider Manual is detailed, available on the website, and provides sufficient information for providers to navigate the plan.

Quality Improvement:

In the Quality Improvement section, Solutions submitted their *2018 Strategic Quality Plan*, work plans, committee minutes, and their *Annual Report: Quality and Performance Improvement Calendar Year 2017* to demonstrate the program Solutions has in place to improve the care and services provided to members and providers. There were no deficiencies found in the Quality Improvement section. Recommendations to update the *Strategic Quality Plan*, the work plan, committee minutes, and the committee membership list were made.

Care Coordination/Case Management:

Solutions is contracted by the state of South Carolina to execute the Medically Complex Children Waiver (MCCW) program. The *MCCW Program Description* outlines the purpose, goals, objectives, and staff roles for Primary Care Case Management (PCCM). Policies define how case management services are operationalized to service members. The Medical Director, Dr. James Stallworth, provides oversight of clinical activities.

CCME's assessment of the Care Coordination/Case Management section includes reviews of the program description, program evaluation, policies, committee minutes, *Provider Manual*, *Member Handbook*, and Case Management files. CCME identified team conferences are not completed according to contract requirements. Case Management policies state team conferences are optional and file reviews reflect team conferences are rarely conducted. Recommendations to address these issues are provided.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review compared to the findings of the 2017 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2017	31	4	0	0	0	35
2018	35	0	0	0	0	35
Provider Services						
2017	3	1	2	0	0	6
2018	6	0	0	0	0	0
Quality Improvement						
2017	6	1	0	0	0	7
2018	7	0	0	0	0	7
Care Coordination/Case Management						
2017	8	7	0	0	0	15
2018	13	2	0	0	0	15

METHODOLOGY

The process used by CCME for the EQR was based on CMS developed protocols for Medicaid MCO/PIHP EQRs and focuses on the three federally-mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects. SC Solutions is not required by contract to conduct performance improvement projects or collect performance measures. Therefore, for this review those activities were not done.

On May 21, 2018, CCME sent notification to Solutions that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Solutions to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Solutions on June 04, 2018 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Care Coordination/Case Management Programs. Also included in the desk review was a review of care coordination/case management files.

The second segment was an onsite review conducted on July 12, 2018 at the Solutions office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or requiring clarification. Onsite activities included an entrance conference; interviews with administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following sections and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between Solutions and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. CCME scored areas of review as meeting a standard, “Met,” acceptable but needing improvement, “Partially Met,” failing a standard “Not Met,” “Not Applicable,” or “Not Evaluated,” on the tabular spreadsheet (Attachment 2).

A. Administration

The Carolinas Center for Medical Excellence (CCME) conducted a review of Administration activities that include the organizational chart, leadership and staffing, general contractual requirements, policy and procedure development and management, confidentiality, data systems and security, compliance, program integrity, and personnel files.

The parent company of South Carolina Solutions (Solutions) is Community Health Solutions (CHS) of America Inc. The CHS Board of Directors (BOD) and Executive Committee provide corporate-level governance to Solutions. Monthly operations meetings are attended by local and corporate leadership and local staff. Thomas McGee is Solutions' Executive Director and oversees day-to-day operations. He reports to the Chief Medical Officer (CMO), Dr. Barbara Freeman. Solutions staff has nearly doubled since the last review. A Lead Care Advocate position was created and filled recently, and Solutions is planning to add another Resource Nurse position. Twenty-nine Care Coordinator positions are filled, and no vacancies were noted. Staff report no identified need for additional Care Coordinator positions, although staffing will be adjusted as necessary to provide services to any new participants.

Solutions policies are organized by department, reviewed annually, and revised as needed. Solutions uses Compliance Manager by Healthicity for policy management. This system prompts annual review of policies and tracks when policies are read by staff. Staff is notified of policy revisions and new policies by email.

Solutions has detailed policies outlining requirements and processes for confidentiality, and the *Employee Handbook* includes information about privacy requirements and consequences for breaches of confidentiality. Employees receive confidentiality and HIPAA training upon hire and annually thereafter. New employees must receive this training prior to receiving access to protected health information (PHI).

The company-wide Compliance Program provides compliance and fraud, waste, and abuse (FWA) oversight to employees, contracted providers, participants, and other individuals or entities with whom Solutions conducts business. The Compliance Officer, Nancy DiGioacchino, is designated to oversee, investigate, and manage all aspects of the Compliance Program. A separate Compliance Committee does not exist; however, compliance issues are reported to the Quality Management Committee (QMC), the Executive Committee, and the BOD. Policies and procedures, the Compliance Program document, the *Employee Handbook*, and the *Provider Manual* provide detailed information about compliance, standards of conduct, and FWA. Employees receive compliance training when hired and annually thereafter. Provider training on compliance and FWA is provided by the Program Operations Coordinator during provider orientation, office visits, and via the *Provider Manual*. The Solutions website provides phone numbers

and email addresses for reporting suspected FWA to both CHS and the SCDHHS Medicaid Fraud and Abuse Hotline.

CCME's review of personnel files confirms Solutions conducts appropriate due diligence to verify staff meet all contractual requirements and are not excluded from participation in state or federal programs.

Data Systems and Security

Solutions has policies and procedures that address data security for protected health information, including measures staff should take to handle PHI in email, instant messaging, voice mail, file transfer, and other electronic mediums. Solutions maintains documentation about how PHI access is managed, including access authorization, access revocation, authorization conditions, and retention of authorization documentation.

Solutions has a detailed disaster recovery plan that specifies the teams associated with response and recovery efforts, steps associated with recovery phases, and contact information for responsible parties. The documentation includes a revision history indicating that the disaster recovery plan is regularly reviewed and revised. Solutions shared documentation of a recent recovery effort that resulted in a successful system restoration.

As illustrated in *Figure 2: Administration Findings*, Solutions achieved scores of "Met" for 100 % of the standards in the Administration section of the review.

Figure 2: Administration Findings

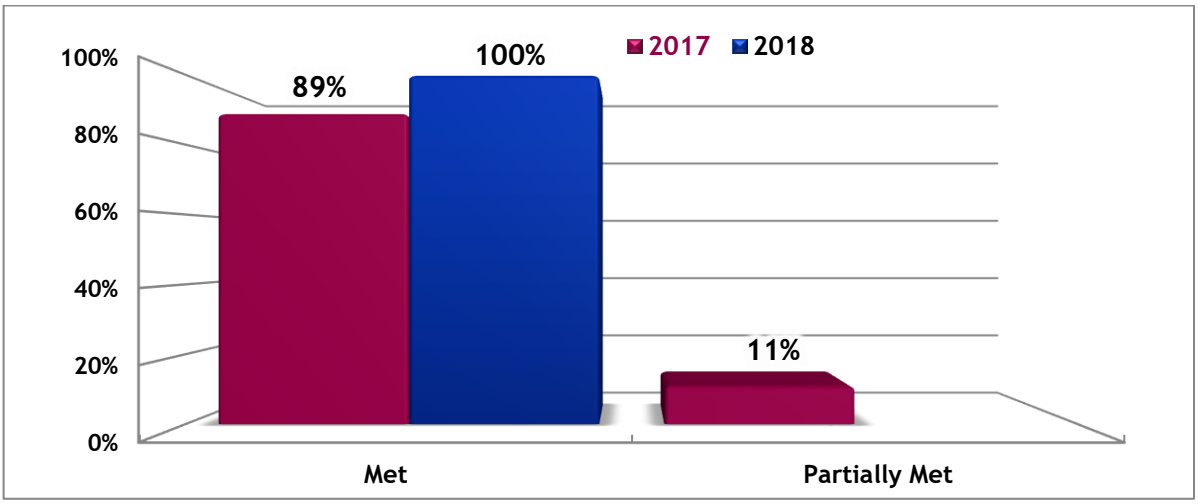


Table 2: Administration Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Organizational Chart / Staffing	Employee personnel files demonstrate compliance with contract and policy requirements	Partially Met	Met
Contract Requirements	Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday	Partially Met	Met
	Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS	Partially Met	Met
Compliance and Program Integrity	Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Solutions added and filled a Lead Care Advocate position recently and is planning to add another Resource Nurse position.
- Care Coordination audit tools were revised and will be used to monitor and educate staff on appropriate documentation.
- Disaster recovery and business continuity documentation is detailed and includes contact information for external resources.

Weaknesses

- Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting defines processes for initial and ongoing monthly exclusion checks to verify employees are not sanctioned or excluded from participating in any federal or state health care program. Attachment CHS.COMP.ALL.02.01a, Agency Exclusion Search Document defines queries conducted. The attachment states “South Carolina” but does not include the specific South Carolina query conducted. Onsite discussion confirmed the *South Carolina Excluded Providers List* is queried at the time of hire and monthly thereafter.

- The 2018 Committee Membership document includes "Monthly Operations Meetings Membership" and indicates members have voting rights; however, onsite discussion revealed this is not a formal committee and members only vote to approve minutes of previous meetings.
- Policy CHS.ISP.ALL.21.24, Privacy Complaint Management defines processes for investigating alleged privacy violations by the Privacy Officer. Onsite discussion confirmed privacy violations are reported to the QMC and Executive Committee, but this is not documented in the policy.

Recommendations

- Revise Attachment CHS.COMP.ALL.02.01a, Agency Exclusion Search Document to specify that the plan monitors the *South Carolina Excluded Providers List*.
- Clarify the Committee Membership document to remove the monthly operations meeting membership or to indicate that this is not a formal committee.
- Revise Policy CHS.ISP.ALL.21.24, Privacy Complaint Management to include information that states privacy violations are reported to the QMC and Executive Committee.

B. Provider Services

Documents and reference materials used by the Plan to educate contracted providers were reviewed for the Provider Services section. The Provider Orientation/Training Policy defines a consistent process for onboarding new providers to the physician network. The Program Operations Coordinator (POC) provides the practice with orientation and training within thirty days of contracting with the company. Onsite discussion confirmed the POC tries to conduct the training meetings face-to-face, but; is also available for web or teleconference training.

The *Provider Manual* is used to educate providers on the Medically Complex Children Waiver program and contractual obligations. A copy is provided to all providers at orientation. The *Provider Manual* is also available on the Solutions website as are links to the *SCDHHS Provider Manuals*, the SCDHHS website, language assistance services, and information about how to report potential fraud or abuse. The *Provider Manual* is detailed and provides sufficient information for providers to navigate the plan.

Figure 3, Provider Services Findings, reflects 100% of the standards in Provider Services received a "Met" score.

Figure 3: Provider Services Findings

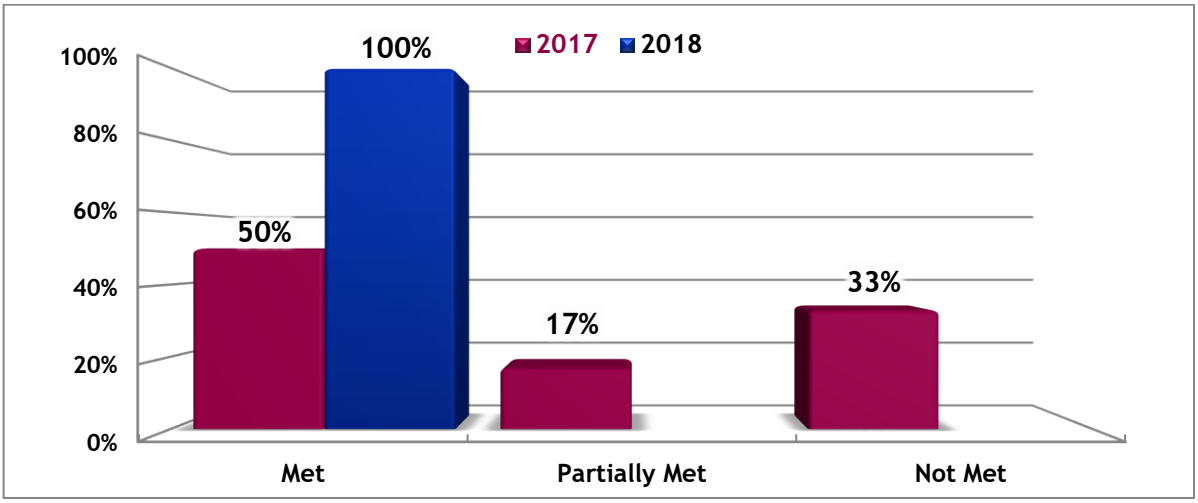


Table 3: Provider Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Provider Services	The organization formulates and acts within policies and procedures related to initial and ongoing education of providers	Not Met	Met
	Initial provider education includes: How to access language interpretation services	Not Met	Met
	The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The *Provider Manual* is detailed and contains sufficient information for providers to navigate the Plan.

C. Quality Improvement

Solutions provided the *2018 Strategic Quality Plan* as evidence that the program is designed to provide the structure and key processes for ongoing improvements of care and services. The *Strategic Plan* includes appendices describing the program-specific details for the WCCW Program, the Chronic Care Management, and the Complex Chronic Care Management Program. Section III: Leadership, pages seven and eight, discusses key roles and program-specific roles. The Quality Program Manager listed on page eight was not a position noted on the *Organizational Chart*. Onsite staff indicated the Director of Quality Programs now also serves as the Quality Program Manager.

Solutions develops a work plan to track initiatives and document progress towards meeting set goals for each initiative annually. Some of the activities on the *2018 Work Plan* contained the same start and completion dates as the *2017 Work Plan*. Solutions staff indicated these are ongoing activities and updates are documented quarterly.

The Board of Directors oversees the Quality Improvement (QI) Program and delegates the day-to-day management to the Quality Management Committee (QMC). It is unclear who chaired the meetings from the documents CCME reviewed. Onsite, Solutions indicated the Chief Medical Officer, Dr. Freeman, serves as Chairperson. CCME recommends noting this in *Committee Minutes* and the *Membership List*.

Figure 4, Quality Improvement Findings reflects that 100% of the standards in Quality Improvement received a "Met" score.

Figure 4: Quality Improvement Findings

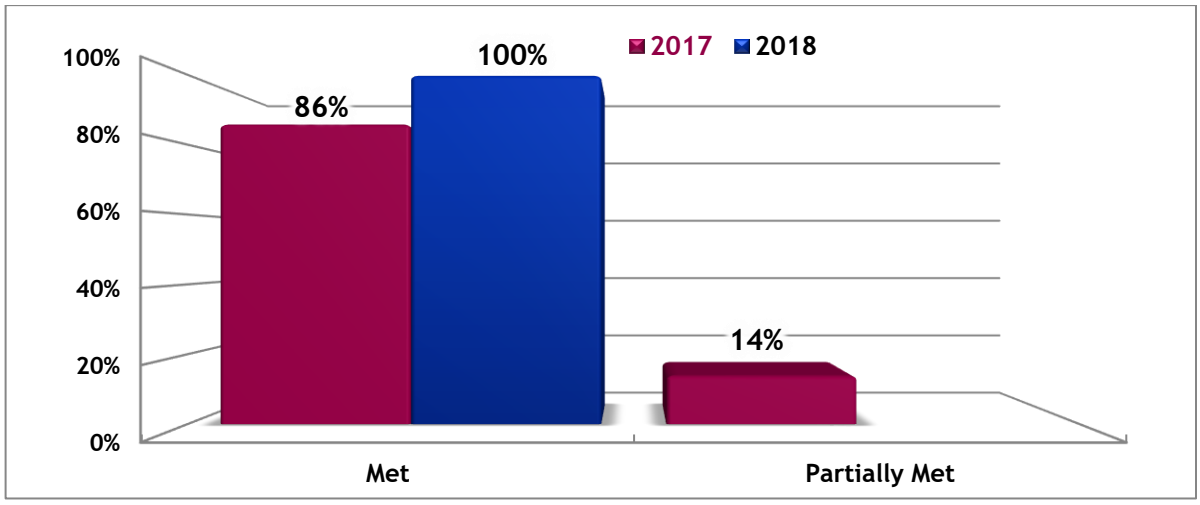


Table 4: Quality Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
The Quality Improvement Program	An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Partially Met	Met

The standards reflected in the table are only the standards showing a change in score from 2017 to 2018.

Strengths

- Solutions provided the *2018 Strategic Quality Plan* as evidence the program is designed to provide the structure and key processes for ongoing improvements of care and services.

Weaknesses

- The Quality Program Manager's role was not updated in the *Strategic Quality Plan* to indicate who is responsible for managing the Quality Program.
- The *2018 QI Work Plan* is not updated. Some of the activities on the *2018 Work Plan* contain the same start and completion dates as the *2017 Work Plan*.
- It is unclear who chaired the Quality Management Committee meetings.

Recommendation

- Update the leadership roles in the *Strategic Quality Plan* to indicate who is responsible for managing the Quality Program.
- Update the start and estimated completion dates for activities that are carried over from one year to the next in the work plans. For ongoing activities, indicate each ongoing activity in the work plan.
- Include who chairs the Quality Management Committee in the *Committee Minutes* and on the *Membership List*.

D. Care Coordination/Case Management

Solutions is contracted with SCDHHS to provide care coordination for the MCCW Program. The *Provider Manual* and *MCCW Program Description* describe the program structure and indicate an enhanced Primary Care Case Management service model. Solutions has several policies to address care coordination processes and frequency of services provided.

Review of Case Management (CM) files indicate Care Coordinators and Care Advocates follow policies as outlined. Level of Care assessments, case management planning, service plan review, and review of claims prior to member contact are conducted as required. Documentation reflects provider offices are actively involved in reviewing participant service plans. Spanish-speaking participants are provided interpreter services and materials in Spanish. The files also indicate quarterly visits are consistently completed; however, team conferences are noted rarely.

Figure 5, Care Coordination/Case Management Findings show 87% of the standards received a "Met" score; 13% were scored as "Partially Met."

Figure 5: Care Coordination/Case Management Findings

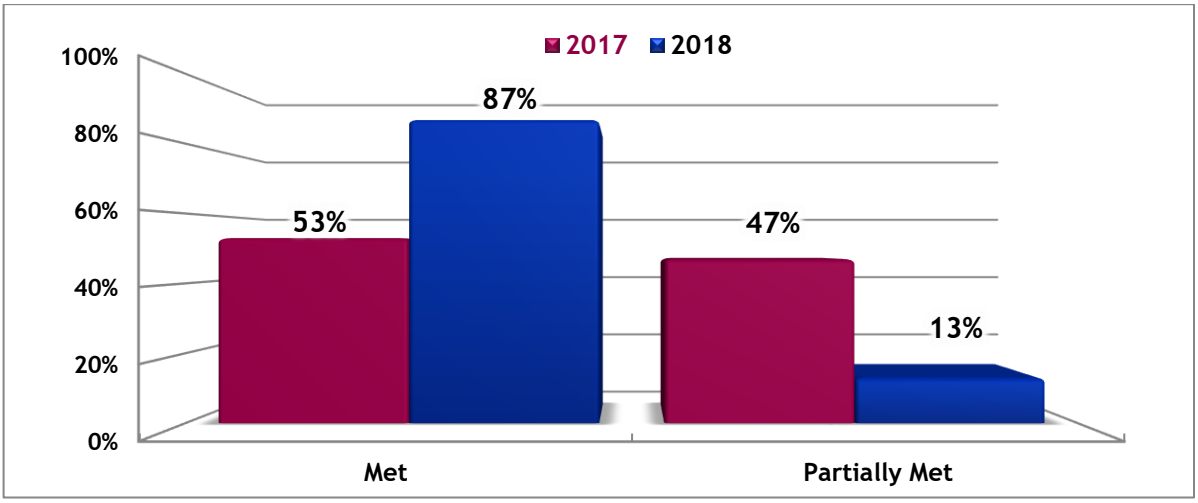


Table 5: Care Coordination/Case Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Care Coordination/Case Management	Policies and procedures and/or the program description address the following: Structure of the program	Partially Met	Met
	Lines of responsibility and accountability	Partially Met	Met
	Intake and assessment processes for Care Coordination/Case Management	Partially Met	Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Care Coordination/Case Management	Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Partially Met	Met
	Processes for reporting suspected abuse, neglect, or exploitation of a participant	Partially Met	Met
	A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided	Partially Met	Met
	File review confirms the organization conducts Care Coordination and Case Management functions as required by the contract.	Met	Partially Met

The standards reflected in the table are only the standards showing a change in score from 2017 to 2018.

Strengths

- Solutions maintained HIPAA compliance with password protection on CM files.
- When applicable, CM files consistently included documents translated in Spanish, such as the *Service Plan Agreement* and *Rights and Responsibilities*.
- Solutions provides Spanish-speaking interpreter services, such as the Tele-language line and in-person interpreters.

Weaknesses

- Policies CHS.CM.MCCW.02.01, Care Coordination Process and CHS.CM.MCCW.02.03, Team Conference describe that either a quarterly visit or a team conference is conducted. Onsite discussions revealed Part A members are offered an optional team conference.
- Policy CHS.CM.MCCW.04.01, Medically Complex Criteria-Down Time does not describe a process for handling paper forms of documentation when electronic access is not available.
- CM files indicate team conferences are rarely conducted, which does not adhere to Policy CHS.CM.MCCW.02.03, Team Conference.

Quality Improvement Plan

- Ensure the correct requirement for frequency of team conferences is noted in policies CHS.CM.MCCW.02.01 Care Coordination Process, CHS.CM.MCCW.02.03, Team Conference and applicable documents.
- Ensure files include documentation showing team conferences are conducted or refused when offered and reflect the processes in Policy CHS.CM.MCCW.02.03, Team Conference.

Recommendations

- Update Policy CHS.CM.MCCW.04.01, Medically Complex Criteria-Down Time to reference the policy on securing paper documentation of PHI or reference the specific policy for handling paper documentation with PHI.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

May 21, 2018

Mr. Thomas McGee
SC Solutions
15 Medical Park, Suite 300
3555 Harden St. Extension
Columbia, SC 29203

Dear Mr. McGee:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2018 External Quality Review (EQR) of South Carolina Solutions is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of the Medically Complex Children's Waiver program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services. The CCME EQR team plans to conduct the onsite visit on **July 12th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **June 04, 2018.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow organizations under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer. An opportunity for a conference call with your staff, to describe the review process and answer any questions, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosures
cc: SCDHHS

External Quality Review

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. If this is a corporate organizational chart, please identify those persons who are responsible for overseeing South Carolina Solutions activities. *From the organizational chart, we will randomly select personnel files to be submitted for review and provide a list of the file components needed.*

3. A description of any updates or changes in requirements disseminated by SCDHHS.

4. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

5. A current provider list/directory as supplied to members.

6. A copy of the current Compliance Plan or policies and procedures addressing compliance, fraud, waste, and abuse.

7. A description of the Quality Improvement, Care Coordination/ Case Management Programs.

8. The Quality Improvement work plans for 2017 and 2018.

9. The most recent reports summarizing the effectiveness of the Quality Improvement, Care Coordination/ Case Management Programs.

10. A committee matrix for all committees. For each committee please include the following:
    a. A copy of the committee charter. Include the committee's responsibilities, meeting frequency, and the required voting quorum.
    b. Membership list and indicate which members are voting members. Include the professional specialty of any non-staff members.

11. Minutes of all meetings for all committees reviewing or taking action on SC Solutions-related activities in June 2017 to May 2018. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

12. A complete list of all members enrolled in the care coordination/case management programs from June 2017 to May 2018. Please include open and closed case files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the

need for care coordination or case management services. From these files we will randomly select specific files for review.

13. A copy of staff handbooks/training manuals, orientation and educational materials.

14. A copy of written information provided to new participants.

15. A copy of materials used for initial provider training/orientation.

16. A copy of any member and provider newsletters, educational materials, and/or other mailings.

17. A copy of the provider handbook or manual, if applicable.

18. A sample provider contract.

19. Please provide a completed Information Systems Capabilities Assessment (ISCA) form as documentation to support the requirements listed in Article VI, Section A (1) of the contract. Areas on the ISCA form not applicable to your organization maybe marked as N/A.

20. A copy of the Business Continuity/Disaster Recovery Plan.

21. A copy of the most recent disaster recovery or business continuity plan test results.

22. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.

23. A description of the data security policy with respect to email and PHI.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://egro.thecarolinascenter.org**

- **submitted in the categories listed**

B. Attachment 2: Tabular Spreadsheet

CCME Data Collection Tool

Plan Name:	**SC Solutions**
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION/ORGANIZATION ACTIVITIES						
I A. General Approach to Policies and Procedures						
1. Policies and procedures are organized, reviewed, and available to staff.	X					Policies are organized by department. As stated in Policy CHS.ADM.ALL.01.01, Policy and Procedure Management all policies are reviewed annually. SC Solutions (Solutions) uses the Compliance Manager application by Healthicity to house and manage policies. This system prompts annual policy review and tracks who read updated policies. Staff are notified of new policies and revisions to existing policies via email.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I B. Organizational Chart / Staffing						
1. The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities:						
1.1 Administrative oversight of day-to-day activities of the organization and available per contract requirements;	X					The Executive Director, Thomas McGee, provides day-to-day monitoring and oversight of program operation and performance, and serves as the contact person for State entities. He reports to the Chief Medical Officer (CMO), Dr. Barbara Freeman, who is responsible and accountable for providing daily leadership and oversight of clinical quality management initiatives. Dr. James Stallworth is a consultant Medical Director whose responsibilities are primarily centered around credentialing and clinical quality functions, as well as serving as a clinical resource for the Case Management team.
1.2 Care coordination and enhanced case management;	X					Alysen McCaughey is the Clinical Nurse Manager responsible for oversight of Care Coordinators and Care Advocates. Solutions has 29 RN Onsite Care Coordinators and 5 Care Advocates who serve approximately 1100 participants. The organizational chart reflects no vacant or temporary positions. Per onsite discussion, the current Care Coordinator to participant ratio is approximately 1:45, with a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						maximum ratio of 1:50. Onsite discussion revealed Solutions staff doubled in the past year. Solutions created a Lead Care Advocate position and plans to add another Resource Nurse position.
1.3 Provider services and education;	X					Jennifer Hamilton, Program Operations Coordinator, is responsible for provider outreach and education.
1.4 Quality assurance;	X					Nancy DiGioacchino is the Executive Vice President, Compliance and Quality. She was recently promoted into this position and was formerly the Vice President of Quality and Compliance. Ms. DiGioacchino holds a Certified Professional in Healthcare Quality (CPHQ) designation. Kristine Paradis is the Director of Quality Services and reports to Nancy DiGioacchino. Ms. Paradis holds a CPHQ designation.
1.5 Designated compliance officer.	X					Nancy DiGioacchino is the Compliance Officer. She holds a Certified Professional Compliance Officer (CPCO) designation.
2. The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, includes the following:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 Criminal background checks are conducted on all potential employees.	X					
2.2 Verification of nursing licensure and license status.	X					Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing and Re-Credentialing defines processes for initial clinical license verification of new employees and ongoing monitoring of licensure status. Licensed personnel must notify his or her manager or department head of any adverse changes in licensure/certification within 3 business days.
2.3 Screening all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs.	X					Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting, confirms the Human Resources (HR) Department performs the initial exclusions review for employees, and the Compliance Department performs ongoing monthly exclusion checks to verify employees have not been sanctioned or excluded from participating in any federal or state health care program. Demographic information for all employees is uploaded into the Compliance Manager system which runs monthly checks of each employee. A report is produced and is reviewed for any sanctions or exclusions. Further review is conducted of any possible sanctions or exclusions matches. Positive matches are reported to the Compliance Officer and then to the appropriate department.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Attachment CHS.COMP.ALL.02.01a, Agency Exclusion Search Document indicates the queries conducted include: •*Office of Inspector General Excluded Individuals and Entities* (exclusions and reinstatements) •*U.S. Food and Drug Administration Debarment List-Drug Product Applications and Food Importation* • *U.S. Food and Drug Administration Disqualified-Restricted-Assurance List* •*Medicare Opt Out List* •*Office of Foreign Assets Control Consolidated Sanctions List & Address, Alias, and Comments* • *Office of Foreign Assets Control Specially Designated Nationals List & Address, Alias, and Comments* •*Office of Research Integrity Exclusion List* •*System for Award Management Excluded Parties List System* The attachment states "South Carolina" but does not include the South Carolina query conducted. Onsite discussion confirmed the *South Carolina Excluded Providers List* is queried at the time of hire and monthly thereafter. *Recommendation: Revise Attachment CHS.COMP.ALL.02.01a, Agency Exclusion Search*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Document, to specify that the South Carolina Excluded Providers List is monitored.
2.4 Ensuring Care Coordinators meet all contract requirements.	X					
2.5 Ensuring staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a Participant's Care Coordination Plan.	X					Employees sign a confidentiality agreement, including an agreement that they will not engage in any outside employment, occupation, consulting, or other business activity that would conflict with obligations to Solutions. A similar statement is found in the *Employee Handbook*.
3. Employee personnel files demonstrate compliance with contract and policy requirements.	X					Upon initial review, several personnel files were incomplete, but required information was supplied during and after the onsite visit. After review of the newly supplied information, files are complete and contain required information.
I. C. Governing Board/Advisory Board						
1. The Organization has established a governing body or Advisory Board.	X					The Board of Directors (BOD) is responsible for ensuring compliance with applicable laws, regulations, contractual obligations, and conduct standards. Executive Committee meetings, including leadership from all lines of business as well as at least one member of the BOD, are held every two weeks to discuss specific issues, including

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						root cause, investigation, and outcomes. Local operations meetings are held monthly. The *2018 Committee Membership* document includes membership for "Monthly Operations Meetings Membership" and indicates members have voting rights; however, onsite discussion revealed this is not a formal committee and members only vote to approve minutes of previous meetings. *Recommendation: Clarify the Committee Membership document to remove the monthly operations meetings membership or to indicate that this is not a formal committee.*
2. The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined.	X					The organization chart displays the corporate reporting structure.
I. D. Contract Requirements						
1. The organization carries out all activities and responsibilities required by the contract, including but not limited to:						
1.1 Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday.	X					The Solutions website home page, "Participants" page, and "Contact Us" page supply the South Carolina Solutions Service Line telephone number (1-888-827-1665) and indicate normal business hours are Monday – Friday, 8:00 a.m. – 5:00 p.m. Instructions are included to call 911

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for a medical emergency. Solutions' website includes the toll-free telephone numbers for SCDHHS Language Services as well as the TTY number.
1.2 Adherence to contract requirements for holidays and closed days.	X					
1.3 Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS.	X					The Clinical Nurse Manager or designee conducts routine supervisory ride-alongs with Care Coordinators during home visits and completes an audit tool for each episode as stated in Policy CHS.CM.MCCW.05.01, Medically Complex Criteria-Onsite Supervisory Visits. Results are presented to the Care Coordinator and Quality Improvement team. If requested by DHHS, the ride-along will occur within 5 business days. Onsite supervision visits are conducted at least annually for each Care Coordinator.
1.4 Organization and participant record retention and availability as required by the contract.	X					Policy CHS.ISP.ALL.11.45, Record Retention Destruction indicates records are retained for a minimum of six years. Records involved in any investigation, public records request, audit, or litigation are not destroyed or disposed of until a resolution to the situation is identified. The policy defines methods of destruction for records and indicates a record of all destruction or disposal of original medical/client records or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						other original documents containing PHI are maintained permanently.
1.5 Participant program education materials are written in a clear and understandable manner and are available in alternate formats and translations for prevalent non-English languages.	X					Onsite discussion confirmed Solutions does not create any written materials provided to participants. Participant materials include a statement in multiple languages that if English is not the primary language spoken, language assistance services are available at no cost. A telephone number and TTY number are included to obtain language assistance.
1.6 Processes are in place to ensure care coordination services are available statewide.	X					Care Coordinator assignments are based on participant population acuity and location. The Clinical Nurse Manager monitors participant locations and reviews Care Coordinator assignments/caseloads at least twice monthly.
I. E. Confidentiality						
1. The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy.	X					CHS.ISP.ALL.11.21, Security & Privacy Training Awareness Requirements and Reminders defines requirements and processes for employee confidentiality/HIPAA training. The policy states employees receive HIPAA training prior to accessing or using electronic PHI. Policy CHS.ISP.ALL.11.12, Information Security & Privacy; Sanction Policy, defines actions taken when employees do not comply with HIPAA and security policies and procedures. The policy defines processes for investigation of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						alleged/suspected HIPAA violations and defines severity levels that are assigned based on the violation severity.
I. F. Data Systems/Security						
1 The organization maintains an appropriate fiscal accounting system.	X					
2. Policies, procedures and/or processes are in place for addressing data security.	X					Solutions has policies and procedures that address the data security of PHI. The policies and procedures detail the measures staff should take to handle PHI in email, instant messaging, voice mail, file transfer, and other electronic mediums.
3. Policies, procedures and/or processes are in place for system and information security and access management.	X					Solutions provided documentation that details how the organization's workforce should manage access to PHI. Specifically, the documentation addresses access authorization, access revocation, authorization conditions, and retention of authorization documentation.
4. The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented.	X					Solutions has a detailed contingency plan. The disaster recovery plan includes the teams associated with response and recovery efforts, steps associated with each recovery phase, and contact information for responsible parties. The documentation also includes a revision history indicating that it is regularly reviewed and updated. Solutions included documentation of recent recovery effort that resulted in a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						successful system restoration.
I G. Compliance and Program Integrity						
1. The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following:						
1.1 Written policies, procedures, and standards of conduct comply with federal and state standards and regulations.	X					Information on fraud, waste, and abuse (FWA), including standards of conduct, is found in the following: •Policy CHS.COMP.ALL.01.01, False Claims Act •Policy CHS.COMP.ALL.01.04, Fraud & Abuse Investigations •Policy CHS.PM.MCCW.01.01, Provider Orientation/Training •*Employee Handbook* •*Provider Manual* •*Compliance Program* document
1.2 A compliance committee that is accountable to senior management.	X					Onsite discussion revealed compliance issues are investigated by the Compliance Officer and are reported to the Quality Management Committee (QMC) and then to the BOD. Policy CHS.COMP.ALL.01.04, Fraud & Abuse Investigations defines processes for Compliance Officer investigations of fraud and abuse allegations and states a quality sub-committee can be convened if additional resources are needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						All investigations of suspected fraud/abuse are documented and logged for QMC reporting. Sub-committee actions/recommendation are presented to QMC. The QMC may offer recommendations which are then sent to Executive Committee for final approval. Policy CHS.ISP.ALL.21.24, Privacy Complaint Management defines processes for investigating alleged privacy violations by the Privacy Officer. If a violation occurred, the Privacy Officer applies appropriate sanctions against the person or entity involved and implements corrective actions as necessary. Onsite discussion confirmed privacy violations are reported to the QMC and Executive Committee. *Recommendation: revise Policy CHS.ISP.ALL.21.24, Privacy Complaint Management to include that privacy violations are reported to the QMC and Executive Committee.*
1.3 Employee education and training that includes education on the False Claims Act, if applicable.	X					Policy CHS.COMP.ALL.01.01, False Claims Act confirms employees are informed of the Federal False Claims Act and related-state specific statutes, whistleblower protection provisions, and internal procedures for the prevention and detection of fraud and abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Compliance training is provided to all employees, contractors, agents, and the Board of Directors upon hire and annually thereafter. Training for various departments is specialized to include relevant examples and materials specific to the department. At the end of training, employees are tested on each module and must achieve a score of at least 80%.
1.4 Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers.	X					The *Compliance Program* document states the Compliance Officer ensures open and effective communication with all employees of the Company and routinely attends staff meetings, corporate events, and other functions. The Company supports an open-door policy. A non-retaliation policy for incidents reported in good faith is supported and enforced. Methods and avenues to report cases of FWA are included on the Solutions website and in other documents.
1.5 Enforcement of standards through well-publicized disciplinary guidelines.	X					Various policies document possible disciplinary actions for violations of conduct standards, the Compliance Plan, etc. The *Employee Handbook* states, "Compliance with this policy of business ethics and conduct is the responsibility of every Company employee. Disregarding or failing to comply with this standard of business ethics and conduct could lead to disciplinary action, up to and including termination of employment."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Provisions for internal monitoring and auditing.	X					
1.7 Provisions for prompt response to detected offenses and development of corrective action initiatives.	X					The *Compliance Plan* and policies define actions taken in response to detected offenses. An investigation file is maintained for all investigated instances and may include interview notes, notification of appropriate internal personnel, root cause, affected parties, applicable guidelines, findings, recommendations, requirements for changes to business practices, system changes, training/education, and personnel actions. Leadership develops corrective action plans related to oversight of personnel involved in incidents and correcting any contributing operational problems resulting in a violation. The Executive Committee reviews investigation reports quarterly. High-risk issues are reported to the Board of Directors at least twice yearly.
1.8 A system for training and education for the Compliance Officer, senior management, and employees.	X					Compliance training is provided to all employees, contractors, agents, and the Board of Directors upon hire and annually thereafter. Annual training is provided via various methods such as classroom, online, “read and sign,” etc. Continuing compliance education is provided through media on the internal website and periodically emailed compliance tips and reminders.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Processes for immediate reporting of any suspicion or knowledge of fraud and abuse.	X					
2. The organization reports immediately any suspicion or knowledge of fraud or abuse.	X					

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
1. The organization formulates and acts within policies and procedures related to initial and ongoing education of providers.	X					Policy CHS.PM.MCCW.01.01, Provider Orientation/Training defines a consistent process for onboarding new providers to the physician network. The policy states the Program Operations Coordinator (POC) provides the practice with orientation and training within thirty days of contracting with the company. Onsite discussion confirmed the POC tries to conduct the training meetings face-to-face but is available for web or teleconference training. The *Provider Manual* contains detailed information and is used to educate providers on the MCCW program and contractual obligations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Initial provider education includes:						
2.1 Organization structure, operations, and goals.	X					
2.2 Provider responsibilities and procedures for obtaining authorization from the state for services and referrals, as needed.	X					Referrals and authorizations are addressed in the *Provider Manual*. The PCP is responsible for medical referral authorizations. The Care Coordinator is responsible for community referral authorization, not SCDHHS. The *Provider Manual* details the services that must be authorized by the PCP.
2.3 Medical record documentation requirements, handling, availability, retention, and confidentiality.	X					The *Provider Manual* addresses medical records including retention timeframes, privacy, obtaining written authorization for release, and details information required for a complete medical record. Medical records reviews are conducted twice a year for Part A children during team conferences with feedback given to providers. Medical record review tracking is reported to the Quality Management Committee.
2.4 How to access language interpretation services.	X					The *Provider Manual* states that SCDHHS provides free services to people with disabilities, such as qualified sign language interpreters and written information in other formats. In addition, for non-English speaking participates, SCDHHS provides qualified interpreters and information written in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						other languages. Toll free numbers are listed in the *Provider Manual*.
3. The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures.	X					The *Provider Manual* is reviewed on an annual basis and is available on the Solutions website. If SCDHHS makes any changes to the MCCW program, Solutions will assist with dissemination of information, as needed.

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. QUALITY IMPROVEMENT						
III A. The Quality Improvement (QI) Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants.	X					Solutions provided the *2018 Strategic Quality Plan* as evidence the program is designed to provide the structure and key processes for ongoing improvements of care and services. The *Strategic Plan* included appendices describing the program-specific details for the Medically Complex Children's Waiver Program, the Chronic Care Management Program, and the Complex Chronic Chare Management Program. *Section III: Leadership*, pages seven and eight, discusses key roles and program-specific roles. The Quality Program Manager listed on page eight is not a position noted on the *Organizational Chart*. Onsite staff indicated the Director of Quality Programs now also serves as the Quality Program Manager. *Recommendation: Update the leadership roles in the Strategic Quality Plan to indicate who is responsible for managing the Quality Program.*
2. An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity.	X					Solutions develops a work plan to track initiatives and document progress towards meeting set goals for each initiative annually. Some of the activities on the *2018 Work Plan* contain the same start and completion dates as the *2017 Work Plan*. Solutions staff indicated these are ongoing activities and updates are documented quarterly. *Recommendation: Update the start and estimated completion dates for activities that are carried over from one year to the next in the work plans. For*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ongoing activities, indicate each ongoing activity in the work plan.
III B. Quality Improvement Committee						
1. The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Board of Directors oversees the QI Program and delegates the day-to-day management to the Corporate Quality Management Committee. The Chief Medical Officer, Dr. Freeman, serves as Chairperson.
2. The QI Committee meets at regular intervals.	X					The Quality Management Committee meets at least quarterly.
3. Minutes are maintained that document proceedings of the QI Committee.	X					A quorum is defined as at least 50% of voting members. Non-voting members are expected to attend and participate but may not vote. Minutes document committee member attendance except for the meeting in January 2018 when attendance was not recorded. The *Committee Minutes* and the *Committee Membership List* did not indicate who chaired the meetings. *Recommendation: Include who chairs the QMC in the Committee Minutes and on the membership list.*
III C. Annual Evaluation of the Quality Improvement Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, Solutions evaluates the Plan's efforts, initiatives, successes, and opportunities for improvement. The *Annual Report: Quality and Performance Improvement Calendar Year 2017* summarized the Plan's quality improvement efforts.
2. The annual report of the QI program is submitted to the QI Committee.	X					

IV. CARE COORDINATION/CASE MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. Care Coordination/Case Management						
1. The organization formulates and acts within written policies and procedures and/or a program description that describe its care coordination and case management programs.	X					The *SC Medically Complex Children Waiver (MCCW) Program Description* briefly highlights the purpose, goals, objectives, and staff roles in the program. Policies and procedures are established to support the implementation and operation of the MCCW Program, including Policy CHS.CM.MCCW.01.01, Intake and Admissions Policy, Policy CHS.CM.MCCW.01.02, Medically Complex Criteria-Assessment, and Policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CHS.CM.MCCW.02.01, Care Coordination Process.
2. Policies and procedures and/or the program description address the following:						
2.1 Structure of the program.	X					Solutions is contracted with SCDHHS to provide care coordination for the MCCW program. The *Provider Manual* and *MCCW Program Description* describes the program structure indicating an enhanced Primary Care Case Management service model. A dedicated clinical Care Coordinator (CC), an experienced registered nurse, manages participants, acts as liaison between family and providers, and is supported by a Care Advocate (CA). The plan of care is directed by board-certified pediatricians.
2.2 Lines of responsibility and accountability.	X					Lines of accountability are denoted in the *MCCW Organization Chart*. The *MCCW Program Description* describes responsibilities for Executive Leadership, Board of Directors, and various committees. The Executive Director, Thomas McGee, is responsible for daily operations and the Medical Director, James Stallworth, is responsible for clinical oversight. Care Coordinators are registered nurses working closely with medical and community service providers. The *Provider Manual* lists the minimum PCP responsibilities and describes requirements for participation in the program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Goals and objectives of Care Coordination/Case Management.	X					Goals and objectives are listed in several documents, including the *Program Description*, *Provider Manual*, and on the Solutions website.
2.4 Intake and assessment processes for Care Coordination/Case Management.	X					Policy CHS.CM.MCCW.01.01, Intake /Admissions Policy, outlines the intake process for the MCCW Program and the Children's Private Duty Nursing Program for children meeting intake criteria and describes the referral process for children not meeting the intake criteria. Policy CHS.CM.MCCW.01.02, Medically Complex Criteria-Assessment, describes the process and purpose of conducting ongoing assessments using the Medical Evaluation Assessment tool.
2.5 Provision of required information to participants at the time of enrollment.	X					
2.6 Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable.		X				During the onsite visit, staff from SCDHHS confirmed, the requirement for quarterly visits and team conferences to be conducted twice per year. Page 1 of Policy CHS.CM.MCCW.02.01, Care Coordination Process notes quarterly visits or team conference will be conducted during months three and nine, and page 1 of Policy CHS.CM.MCCW.02.03, Team Conference reflects team conferences are offered twice a year to all part A members. During onsite discussions Solutions explained either a quarterly visit or a team conference is conducted,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Part A members are offered a team conference for which they have the option to accept. *Quality Improvement Plan: Ensure the correct requirement for frequency of team conferences is noted in policies CHS.CM.MCCW.02.01, Care Coordination Process, CHS.CM.MCCW.02.03, Team Conference, and applicable documents.*
2.7 Processes to develop, implement, coordinate, and monitor individual care coordination plan with the participant/caregivers and the PCP.	X					
2.8 Processes to ensure caregiver/parent participation in and understanding of the Care Coordination Plan.	X					Solutions ensures the responsible party is informed of their participation in the Care Coordination program by reviewing pertinent documents in the admission packet, such as the Admission Agreement form, the Rights and Responsibilities form, and the Consent for Case Management/Freedom of Choice form. Applicable policies outline the process for completing these documents.
2.9 Process to regularly update and evaluate the care coordination plan on an ongoing basis.	X					Solutions has policies established to ensure the care coordination process is updated and evaluated on a regular basis. Policy CHS.CM.MCCW.02.01, Care Coordination Process describes the care coordinator will monitor the responsible party's progress with obtaining the necessary services and intervene on their behalf if needed. Scheduled interactions will occur during monthly calls, quarterly visits, team

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conferences, semi-annual and annual visits. Policy CHS.CM.MCCW.01.08, Care Planning indicates the care plan will be reviewed monthly with the responsible party and updated accordingly. Additionally, the *Provider Manual* informs providers of their responsibility to participate in biannual team conferences to review the care pan.
2.10 Processes for following up with participants admitted to the hospital and actively participate in discharge planning.	X					
2.11 Processes for reporting suspected abuse, neglect, or exploitation of a participant.	X					Policy CHS.CM.MCCW.01.12, Child Protective Services describes the process for the CC to review child protective services forms with the responsible party and the process for reporting suspected neglect or abuse to Child Protective Services.
2.12 A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided.	X					Policy CHS.CM.MCCW.04.02, Medically Complex Criteria-Back Up Service Provision, indicates the Clinical Nurse Manager will assign a participant to another CC or CA in the event the primary CC or CA is unable to provide care. Policy CHS.CM.MCCW.04.01, Medically Complex Criteria-Down Time, describes the process for the CC and CA to continue managing participant's needs when electronic access is not available, noting paper forms will be utilized for temporary documentation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						During the onsite, Solutions explained the Resource Nurse/Trainer fills in for the CC, in instances of vacation or illness, to ensure participants have continual services. Additionally, it was clarified that when paper forms are used for temporary documentation the CC or CA disposes of it in a shredder provided for them, after the computer system becomes available. Solutions added, there are policies for proper handling of paper forms of PHI. *Recommendation: Update Policy CHS.CM.MCCW.04.01, Medically Complex Criteria-Down Time to include the process for handling paper forms of PHI or reference the specific policy for handling paper documentation with PHI.*
3. The organization provides a written, formal evaluation of the Service Plan to SCDHHS every 6 months or upon request.	X					During onsite discussions Solutions explained formal service plans are entered in Phoenix and can be reviewed on an on-going basis in addition to every 6 months. The Phoenix documentation system indicates when the service plan has been reviewed.
4. The organization conducts Care Coordination and Case Management functions as required by the contract.		X				Fifteen CM files were reviewed. Documentation reflect appropriate interpreter services, such as the Tele-language line or in-person interpreters, are utilized when servicing participants and their families whose primary language is not English. Files also indicate Care Coordinators and Care Advocates follow established policies, such as CHS.CM.MCCW.02.01 Care Coordination Process, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CHS.CM.MCCW.01.08, Care Planning, to ensure comprehensive, coordinated care for all participants as required. However, sampled files indicate that team conferences are rarely conducted, which is not consistent with *Policy CHS.CM.MCCW.02.03, Team Conference*. SCDHHS staff present at the onsite confirmed that the requirement is for both team conferences and quarterly visits to be performed. Solutions explained either a quarterly visit or a team conference is offered to Part A members for which they have the option to accept and often the RP prefers quarterly visits instead of team conferences. Additionally, the responsible party has been identified as a barrier to completing team conferences, and Solutions will collect additional data and initiate a quality improvement project to address it. *Quality Improvement Plan: Ensure files include documentation that team conferences are conducted or refused when offered and reflect processes in Policy CHS.CM.MCCW.02.03, Team Conference.*